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New Challenge for Addiction Care-MSM with Chemsex Consumption Pattern

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Abstract: The present article reflects on the need for Men who have sex with men (MSM) with addicted chemsex consumption behavior and presents a specified treatment concept. The individual therapeutic challenges for this group of users consists of the distinct functionalization of substance use for initiating and engaging in sexual activity as well as the resulting strong association between sexual activity and substance use and vice versa. Intensive psychotherapeutic and addiction treatment is needed to decouple substance use and sexual activity, with the ultimate goal of promoting sexual activity without substance use. This treatment initially starts with stimulus control and continues to exposure and re-initiation of sexual activities without substance use. Since the first treatment inquiries through “Aidshilfe Cologne”, the salus klinik Huerth, department of addiction care, has developed a treatment approach for MSM with addicted chemsex behavior, which is focused on the function of drugs for sexual activity and aims at encouraging a lifestyle of engaging in sexual activity without substance use. The article provides information regarding the necessity of a specific treatment approach by comparing initial data about differences between MSM with chemsex as compared to men with other substance use behavior and examines implications for the practice.

Keywords: MSM, Chemsex, Minority Stress, Treatment Approach

1. MSM with Chemsex Consumption Pattern - Prevalence[1]

The term "chemsex" does not yet have a universally accepted definition. With regard to MSM (men who have sex with men), the definition by David Stuart of the Chelsea and Westminster Hospital NHS Foundation Trust in London is certainly seminal:

"Chemsex" is a word invented on geo-sexual networking apps by gay men (and adopted by the gay men's health sector) that defines a syndemic of specific behaviors associated with specific recreational drugs, and is particular to a specific, high-risk population.

Though the media spotlight may have distorted the term to define the use of any drugs in sexual contexts by any population, chemsex actually refers to the use of any combination of drugs that includes crystal methamphetamine, mephedrone and/or gammahydroxybutyrate (GHB) / gammabutyrolactone (GBL), used before or during sex by men who have sex with men (MSM) [14].

The salus klinik Huerth, a modern rehabilitation clinic for the treatment of addiction diseases in the greater Cologne area, first encountered with the topic of MSM (men who have sex with men) with chemsex use patterns in 2014 with a treatment request from the “Aidshilfe Cologne”. The question arose as to how big the problem of dependent chemsex use actually is and to what extent this patient group needs supplementary treatment modules in terms of content and methodology, beyond the "state of the art" withdrawal treatment.

Social law in Germany provides for inpatient rehabilitation financed by pension insurance or health insurance for various somatic as well as mental illnesses, including addiction. Regular treatment periods can range from 13 to 26 weeks for initial treatment. Referrals to rehabilitation are usually made

[1] First published in german in SUCHT (Vol. 66 No.6), Hogrefe, Bern.

through public, church or independent addiction counseling centers. The "Aidshilfe" is an NGO for HIV-positive fellow citizens. Since a high percentage of MSM with (addicted) chemsex use patterns are also HIV-positive, they also seek counseling contact with the local counseling centers of the Aidshilfe, although these are not classically assigned to the addiction counseling centers [7].

After the first inquiries by the Aidshilfe Cologne, the question arose as to how big the problem of addicted chemsex use actually is and to what extent this patient group needs supplementary treatment modules, both in terms of content and method, beyond the "state of the art" withdrawal treatment.

"Chemsex" is understood according to the definition of D. Stewart as a specific consumption pattern among MSM with regard to preferred substances for muscle relaxation and libido enhancement, functionality of consumption (especially intensification of the sexual experience) as well as specific consumption settings (use of common portals, use of saunas, darkrooms, private sex parties). Methamphetamine, GHB/GBL, ketamine, mephedrone, amyl nitrite are the main substances used [14].

Addicted use according to ICD-10 is given if the common diagnostic criteria are present. Classical access routes to the rehabilitation of addiction diseases are usually via the municipal, independent or church-based addiction counseling centers or via the rehab clinics. In initial cooperation discussions with the Aidshilfe Cologne, it became clear that MSM with chemsex use patterns have increasingly sought contact with the Aidshilfe since 2013, when their consumption control capacity decreases and they are confronted with negative consequences of consumption (in social, health terms). Aidshilfe Cologne reported an increase in requests for counseling from persons concerned, but also from physicians specialized in HIV treatment, emergency departments, hospitals and HIV specialist clinics [9]. The German Chemsex Survey 2018 [12] shows that the men surveyed are well informed about the classic access routes to the addiction support system, but they often do not initially define themselves as addicted to addictive substances. Also with the consumption motive "substance use for sexual performance enhancement“, they may not feel addressed by the known counseling services and they are also afraid of stigmatization due to their sexual orientation by counselors/practitioners [5, 7, 8].

Obtaining robust data on prevalence in relation to MSM with a substance use disorder of the chemsex-type pattern is hardly possible at this stage. Current European and German studies [2, 4, 10, 12] on this topic provide information on the extent and frequency of substance use in MSM sexual practice, but do not provide reliable insight into the extent of dependence requiring treatment. Moreover, the chosen "community-based" access routes (e.g., via AIDS support, relevant internet portals) to respondents probably only reach a section of the target group [1].

In the 2017 European EMIS study [13], a pan-European online survey from October 18, 2017, to January 31, 2018, of nearly 128,000 MSM from 50 countries, 82% of respondents said they had been under the influence of drugs in less than half of their sexual encounters, and 44% said they had never been. About 7%, on the other hand, said this had almost always or always been the case. According to the 2017 EMIS survey, alcohol and nicotine use is also common among gay and bisexual men. Among drugs, cannabis was the most prevalent. The typical chemsex use pattern was found in only a smaller percentage of respondents (e.g., 7% methamphetamine, 5% mephedrone), but the extent to which use had developed into problematic or addicted use was not asked. If one follows these results, only a small part of the MSM group shows a chemsex use pattern analogous to the definition of D. Stuart [14]. The demand for treatment places in our clinic, on the other hand, indicates that there is a need for treatment for this relatively small part of the MSM group with a corresponding development of addiction. In 2016, 13 and in 2019 already 44 MSM with an addicted chemsex use pattern, who mainly came from the metropolitan area (Berlin, Cologne, Hamburg, Munich), were treated.

2. Sexuality – A Relevant Topic in Addiction Treatment

Sexuality is a rather neglected topic in addiction care. Since in the MSM user group the functionalization especially of stimulating substances with a high dependence potential in sexuality is of high importance, not addressing and dealing with this connection proves to be particularly drastic.

Furthermore, Anglo-American studies indicate that MSM and other sexual minorities have particular and additional risks of illness (increased rates of mental illness and suicidal acts) that are not genetic or biological in origin, but may be co-induced by structural patterns of devaluation and resulting internalized homonegativity: *Minority stress model"*[4, 11, 15].

Our initial clinical experience in 2015 confirmed an increased rate of mental illness and distress in this patient group. To objectify this assessment, we conducted an initial in-clinic evaluation.

Data from the 2015-2017 discharge cohorts and all rehabilitants with a chemsex use pattern (CS: n=40) compared with a male comparison group with a different use pattern (VG: n=1371) were analyzed. Differences between CS and VG were tested using χ^2- and Welch-t tests. The rehabilitants with chemsex use patterns were significantly older (CS: 39 yr; VG: 35.8 yr; t (43.1)=2.23, p=.05; Cohen's d=0.27), more likely to have high school diplomas (CS: 57. 5%, n=23; VG: 21.8%, n=299; χ^2 (.001; 3, N=1411)=25.365) and more likely to be in employment (CS: 50%, n=20; VG: 30.1%, n=413 χ^2 (.02; 1, N=1411)=5.9998). No differences were shown with regard to partner situation and inability to work at admission. In addition, the two groups differed in the three most frequent initial diagnoses. CS: 1. stimulant addiction F 15.2, 37.5%; 2. multiple addiction F 19.2, 30%; 3. alcohol addiction F 10.2, 12.5%. VG: 1st alcohol addiction

F 10.2, 38.51%; 2nd multiple addiction F 19.2, 24.36%; 3rd cannabis addiction F 12.2, 21.74%. The CS group has more comorbid F diagnoses (without F1) than the VG, more somatic comorbid diagnoses especially regarding HIV (CS: 62.5%; VG: 0.97%) and hepatitis C (CS: 25%; VG: 1. 35%). They exhibited higher general psychological distress in test diagnostics at baseline (GSI, CS: 1.26; VG: 0.93; t (41.9)=3.05, p=.004; Cohen's d=0. 46) as well as higher scores regarding the scales Uncertainty (CS: 1.73, VG: 1.10; t (41.1)=3.57, p <.001, Cohen's d=0.63), Depressiveness (CS: 1.66, VG: 1.12; t (41.5)=3.48, p=.001, Cohen's d=0. 56), anxiety (CS: 1.40, VG: 0.99; t (41.4)=2.98; p=.005, Cohen's d=0.49), and psychoticism (CS: 1.31, VG: 0.92; t (41.6)=2.75, p=.003; Cohen's d=0.43) (see Figure 1). *Concluding from this, a higher psychological vulnerability as well as specific treatment issues (among others due to the increased rate of somatic comorbidity) were confirmed and thus a special need for treatment of this target group.*

Figure 1: Brief Symptom Inventory (BSI)

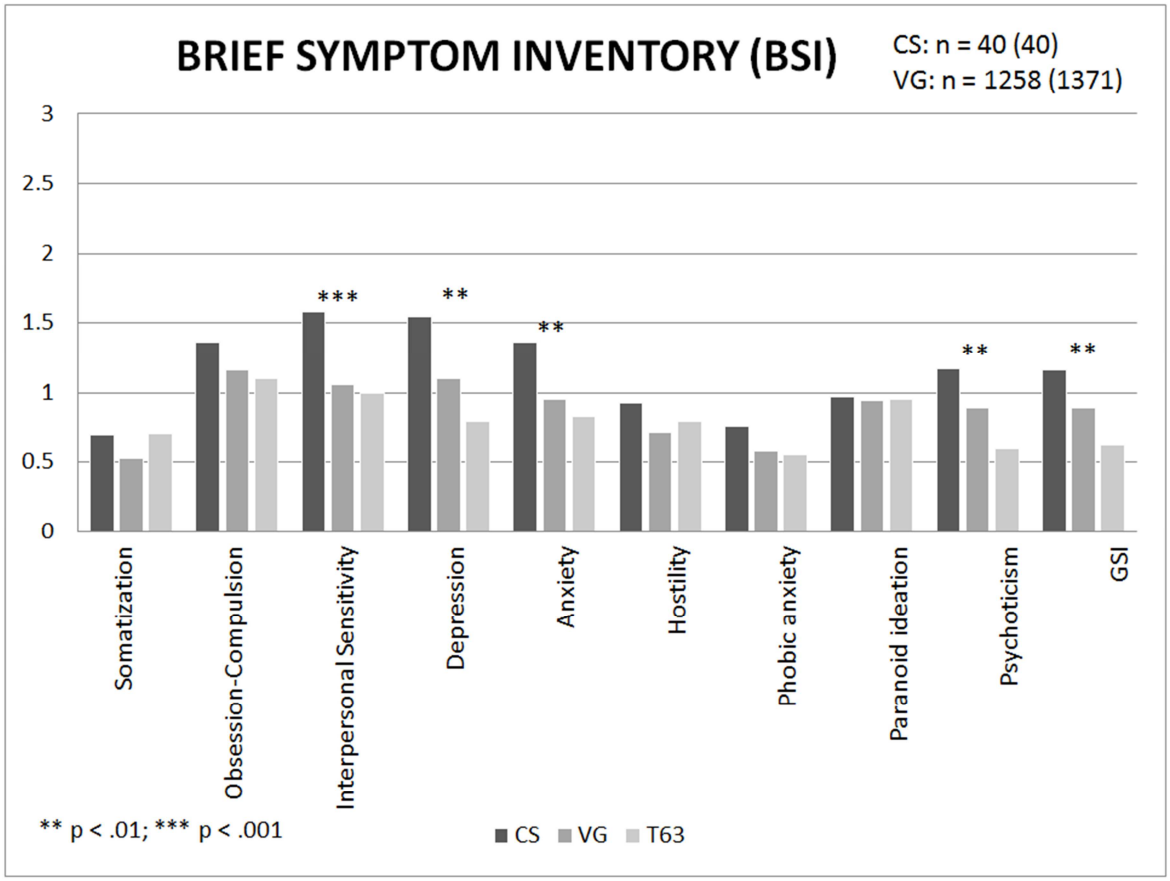

Figure 1. *Psychological distress assessed with BSI [6] at baseline in rehabilitants with chemsex use patterns (CS) and male addiction rehabilitants without chemsex use patterns (VG). T63=T-score/Norm of BSI/Cut Off.*

3. MSM and Chemsex – Consumption Patterns – Treatment Concept

The intensive link between substance use and sexuality in this target group requires knowledge of this living environment, of the special "subcultural" meeting places (which have historically arisen from minority status, among other things), and of the special requirements for relapse prevention.

Clinical work with this target group often reveals, in addition to a substance addiction requiring treatment, an increased sexual desire and acting out with others or with oneself and an intensive use of pornographic content and dating portals, as well as a significantly higher burden of STIs, hepatitis and HIV.

This presents special challenges for treatment. Thus, we found that relapses in the first weeks of treatment were associated with high risks (severe intoxication over a few days, for example) resulting from strong sexual desire, which in turn also triggered strong consumption desire due to coupling - and vice versa.

In order to provide patients with a low-crisis entry into treatment and, at the same time, to resolve the strong fixation on sexuality that was observed in particular at the beginning, we developed a 3-phase model as well as supplementary recommendations and agreements to the treatment contract.

Three-phase model:

1st phase: stabilization/"stimulus protection": In the first 4-6 weeks, agreement on sexual abstinence (worked out individually): dealing with common internet portals

(deactivation if necessary), pornography consumption, going to scene locations, masturbation) with the aim of loosening the fixation on sexuality.

2nd phase: Exposure: in individual therapy and in the indicative group "Lust und Rausch" (lust and druggy), a risk profile with regard to external settings and internal sets is developed on the basis of a traffic light model in order to thus prepare the resumption of (substance-free) sexual activities, to carry out a risk assessment and to deal with associated emotions as well as to reflect on these experiences.

Phase 3: Reality testing: By means of so-called stress tests on the weekend in the living environment (from the 29th day of treatment) and in the last third of treatment during a 5-day reality training, what has been learned is to be tested in the respective living environment.

Supplementary recommendations and agreements on dealing with sexuality, dating apps and pornography, going to "scene locations," using sexual enhancers and substance recidivism in the context of sexuality are discussed and are part of the treatment agreement.

In the development of our *treatment standards* and content conception of a specific indicative group for MSM with chemsex use patterns, we were guided both by the formulated needs of the patients, our own assessment and by the first Quadros study [3] funded by the German Ministry of Health.

We were unable to draw on a reliable needs assessment and abstinence-oriented treatment approaches in methodology and content, as these were not yet available for this particular patient group and were initially developed by us in therapeutic practice and evaluated in 2018 with regard to their effectiveness in an initial in-clinic evaluation of the initial and final diagnosis. In addition to the aforementioned sources, our treatment approach is behavioral and integrates systemic approaches as needed.

A *focal treatment team* has been established that both leads the group counseling and is responsible for individual therapy treatment. Due to the substantial further education about the life and consumption world as well as the sexual practice of MSM, the meanwhile well-founded clinical experience of the main treatment team members, a good treatment quality is guaranteed.

In addition to the addiction and biographical anamnesis, it is essential to take a *sexual anamnesis* in this patient group. The responsible physician takes a history of any sexual dysfunctions that may be present. The responsible therapist collects the current sexual behavior and experience, the use of media with pornographic or consumption-related content, the disorders of sexual preference (in consumption and independently), disorders of gender identity, questions about sexual orientation and special sexual preferences (in consumption and independently), general questions about partnership, preferred relationship model and questions about psychosexual development including stressful events.

In order to counteract phenomena of exclusion and to enable experiences of recognition and solidarity, we have integrated the MSM chemsex patients into two otherwise heterogeneous addiction therapy groups (on average, 6 of 12 patients are chemsex users per group). The regular groups make it possible for the MSM chemsex patient group to break the thematic fixation on sexuality and substance use and at the same time, it enables experiences of support by at least five other patients with the chemsex issue.

Supplemental weekly *individual therapy* can address particularly shameful aspects of current sexual practice and psychosexual development.

Couples Treatment/Systemic Treatment Approaches: Same-sex couples with an addiction disorder may have simultaneous or delayed treatment. Likewise, for patients living in partnership, systemic therapy components include counseling interviews with relatives and joint participation in a family seminar.

In addition to the treatment in heterogeneous reference groups (see above) analogous to our biopsychosocial treatment approach of addiction diseases, we have a specific offer for the MSM group with chemsex use patterns: *Indicative Group (IG) Lust and Druggy.*

In the IG, which was conceived at the beginning of 2016 and has been further developed to date, special attention is paid to the topic of "chemsex use patterns among MSM" and their life-world relevance.

Target groups are:

a. MSM who show a strong functionalization of psychoactive substances in sexuality.
b. MSM who engage in so-called "chemsex"
c. MSM who, in addition to substance use, show an increased sexual desire and/or critical media use.

Contents of “IG Lust and Druggy”: We have developed our own manual, based on our clinical practice, which, situationally supplemented by current topics of the patients (e.g. preparation of a "sex date", processing of relapse, updated partnership conflicts), deals with the following complexes of topics:

a. Functionality of different substances during sex
b. Functionality of sexuality (independent of substance use).
c. What needs are met in the context of sexuality?
d. "Hypersexuality"
e. Psychosexual development and, if applicable, resulting effects on sexual and consumption behavior
f. Homonegative experiences and internalized homonegativity and resulting effects on sexual and consumer behavior
g. Reapproach to a substance-free sexuality - risk assessment / traffic light model
h. Outlook on future sexual life
i. Advantages and disadvantages of different relationship models
j. Relapse and behavior after relapse

Experience with the treatment concept to date and possible effectiveness review.

The increasing treatment numbers since 2015 (in 2016 still 13 treatment courses, in 2019 already 44) as well as the feedback from the counselor and treatment network confirm the need for a specified treatment concept.

A systematic review of the effectiveness of the treatment concept for patients with chemsex use patterns, especially also at the time of collection of the 12-month catamneses, is still pending. In particular, the question of whether the treatment concept described above leads to improved treatment success is of interest. To date, no systematic data collection with a suitable comparison group, e.g. in the sense of a waiting control group, has been possible. Possible so far were evaluations with the existing standard diagnostics and the comparison with other male addiction rehabilitants who do not have a chemsex use pattern (VG), or a sole consideration of the course data of the rehabilitants with chemsex use pattern (CS). That is, the initial question pursued was whether CS improve at all over the course of treatment, despite showing increased psychological distress in the initial diagnosis and increased psychological as well as physical comorbidity. Initial evaluations of the change between entry and exit diagnostics show that CS test scores improve significantly in the BSI (n=28) and in all subscales (see Figure 2). Differences between input and output diagnostics were tested with the Welch t-test for dependent samples. The GSI decreases on average from 1.28 to 0.63 (t (27)=5.30, p <.001, Cohen's d=1.00). In the CS group, there are the same number of regular completions (despite higher psychological stress factors) as in the VG (CS: 75%; VG: 74.2%), which we take as confirmation of the effectiveness of our treatment concept. The regular completions also correlate with the satisfaction of the rehabilitants with the treatment explored in the final interviews.

Figure 2: BSI development "Chemsex"

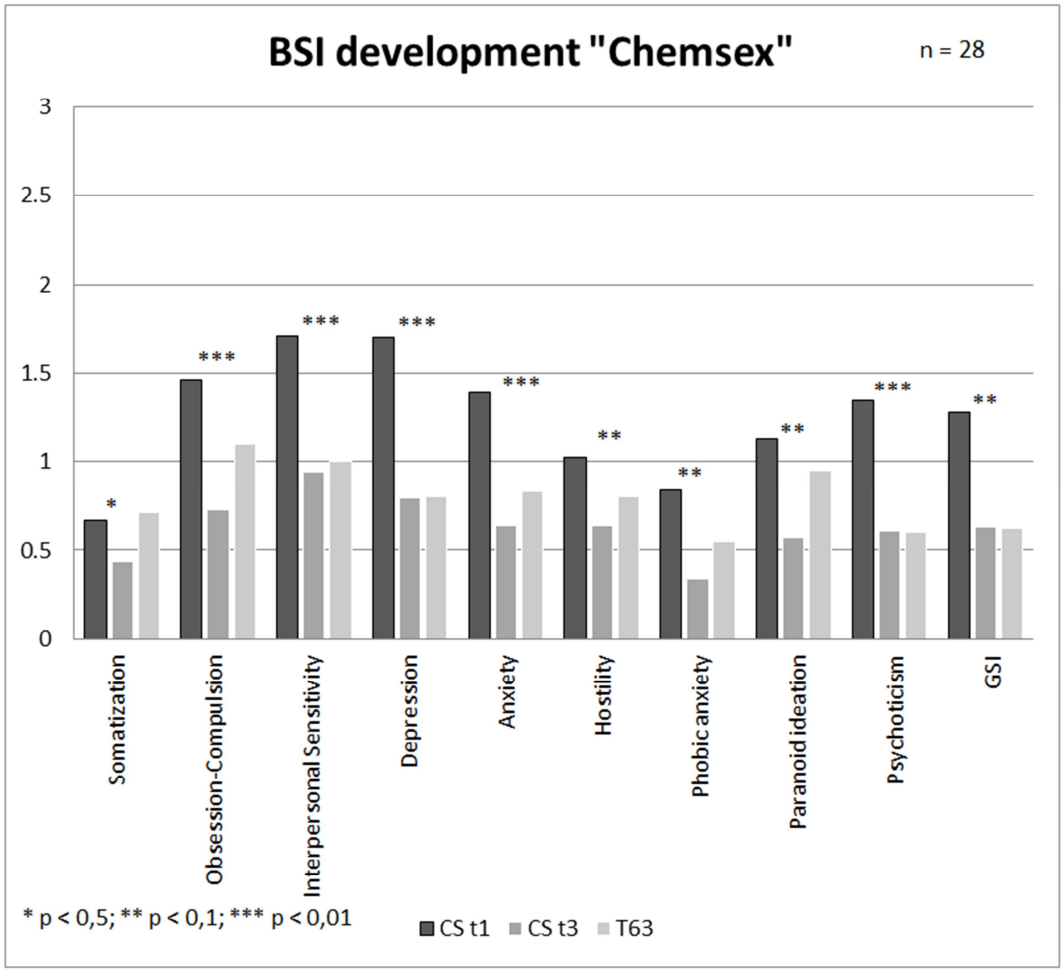

Figure 2. *Change over the course of treatment in BSI [6] within the group of rehabilitants with chemsex use patterns (CS). T63=T-score/norm value of the BSI/Cut Off.*

4. Discussion

a. On the positive side, the increasing demand for treatment places for the focal treatment "MSM with chemsex use patterns" and the satisfaction of the rehabilitants can be seen. Furthermore, the majority of regular treatment completions and the significant improvement in standard diagnostics are positive indications of treatment success.

b. Limitations of the previous evaluations result in particular from the inpatient setting of rehabilitation, in which it has not yet been possible to enable a study design with a waiting control group and the targeted collection of disorder-related dependent variables. Furthermore, the examination of the clinical

significance of the statistical differences found as well as the examination of long-term effects on abstinence after 12 months is still missing.

5. Conclusion

Our within-clinic study shows significantly higher psychological distress among MSM with dependent chemsex use patterns in contrast to the male comparison group. Clinical experience over the past 7 years also makes therapeutic necessity to address issues such as psychosexual developmental factors in a heteronormative society, experienced or/and expected experiences of exclusion, and resulting internalized homonegativity.

The following concrete conclusions for a successful treatment of MSM with dependent chemsex use result: It is recommended to establish a medical, psycho- and addiction-therapeutic treatment focus team, which has the corresponding expertise. An exploration of the current sexual and consumption behavior as well as a detailed sexual anamnesis, especially of the psychosexual development, must be mandatory. In order to dissolve the fixation on "sexuality" that is often present at the beginning of treatment, the MSM should be integrated into an otherwise heterogeneous reference group with simultaneous participation of the MSM in a manualized program to treat the cognitive and emotional coupling of substance use with sexuality. An orientation toward sexual abstinence in the first weeks of treatment has proven effective in breaking the fixation on sexuality and thus initiating a controlled reapproach to substance-free sexuality.

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